State of Hawaii
Department of Health

Child and Adolescent
Mental Health Division

Performance Improvement Recommendations:
Addendum to Annual Evaluation Report Fiscal Year 2003

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Purpose

The purpose of this report is to summarize recommendations for potential avenues to improve the quality and comprehensiveness of services provided by the Hawaii Child and Adolescent Mental Health Division (CAMHD). These recommendations stem from the review and discussion of the CAMHD Annual Evaluation Report for Fiscal Year 2003. The annual evaluation results have been presented and discussed at several CAMHD stakeholder meetings including the Performance Improvement Steering Committee (PISC), Network Meeting, and Provider Meeting. Comments and suggestions from these meetings were combined with the results of a detailed discussion by a PISC workgroup assembled for this purpose. The workgroup consisted of the following persons:

Keli Acquaro, M.A.	Hawaii Family Guidance Center Branch Chief
Al Arensdorf, M.D.	CAMHD Medical Director
Eric Daleiden, Ph.D.	CAMHD Research and Evaluation Specialist
Martin Hirsch, M.D.	Honolulu Oahu Family Guidance Center Clinical Director & Acting Branch Chief
Ana Rosal, M.Ed	Catholic Charities Provider Representative
Mike Wurtz, L.S.W.	PACT Provider Representative

Information from these different sources was assembled and compiled by the author of this report and responsibility for any errors of omission or misrepresentation resides with the author, but the opinions expressed are not necessarily those of the author. The offering of these numerous recommendations should not be construed as a belief that all of these recommendations could be feasibly implemented. On the contrary, careful selection of key initiatives and implementation of well-defined improvement programs with sufficient dosage was recommended.

Recommendations

Population Decline and Availability of Services

Considerable discussion focused on the large decline in CAMHD's overall client population and strategies for improving availability of services. Emphasis was placed on understanding and extending the reach of the Severe Emotional and Behavioral Disturbance (SEBD) referral process and continued development of partnerships with the juvenile justice system.

Understand and communicate CAMHD product lines

It was speculated that although both internal and external customers of CAMHD's services have a good understanding of the availability and procedures for accessing CAMHD services through the education system, other eligibility criteria and mechanisms for receiving CAMHD services are still relatively poorly understood throughout the system. Several recommendations were offered to remedy this confusion.

CAMHD should generate a standard set of definitions and create a common language for identifying its various service mechanisms (e.g., educationally-related, justice-related, and SEBD/QUEST-related). This language should be consumer friendly and used consistently throughout the system. It was recommended that such terminology be created in the context of developing marketing materials that clearly delineate CAMHD's various product lines. Development of materials should be guided by a marketing plan targeting improved awareness of, knowledge of, and positive attitude toward CAMHD services among multiple stakeholder groups (e.g., families potentially in need of services, primary care physicians, interagency partners, CAMHD providers, and CAMHD personnel). It was recommended that CAMHD approach local universities to create internships to help develop such a plan.

Identify and address barriers to assessment and enrollment

Several potential barriers to receiving eligibility assessments and enrolling in CAMHD's services were discussed. Such barriers were described at the referring agency level, the front-line worker level, and the systems level. The primary barrier identified at the referring agency level was lack of knowledge or timely awareness of eligibility for and access to CAMHD services. In addition to introductory training regarding CAMHD services for potential referral sources, a schedule of regular maintenance training was recommend. This could take the form of a periodical (e.g., monthly newsletter) describing how to access services or more formal training sessions. As mentioned above, developing a presence of consumer-friendly materials at key referral sites (e.g., primary care physician offices) may promote awareness of CAMHD services at important decision-making times.

At the front-line worker level, several strategies were discussed for increasing the likelihood of establishing personal relationships between referral and engagement personnel. These strategies may be generally summarized as promoting co-location of personnel or building consultation services with CAMHD's partners. Some Family Guidance Centers described success with establishing office hours at particular schools to provide some co-location of personnel with little cost. Continued development of the peer review process was also recommended. CAMHD could seek to expand its consultation services, such as that provided at Detention Home, to specific "clinics" that may be held at referring agencies. In addition to schools and juvenile justice sites, consultation services could be targeted to Department of Human Service and QUEST health plan service sites.

In addition to promoting personal relationships, systemic barriers may challenge the engagement of front-line workers. For example, care coordinators may experience increased workloads as punishment for strongly promoting referral of new clients. Management may be able to assure care coordinators that new personnel will be hired to prevent caseloads from increasing significant, but lags in hiring new personnel are still likely to result in temporary workload increases. Strategies that help minimize workload increases and circumscribe lags in filling positions are recommended to address this potential barrier. Some strategies for building variable case management capacity that were generated during brainstorming included developing a central relief pool, rotating some personnel across centers to address referral increases, and identifying a private provider who could supply temporary case management services or personnel. Although the feasibility of various strategies was unknown, it was recommended that a concrete plan for addressing such issues be developed and disseminated, rather than just a vague promise that these issues will be dealt with when they occur.

At the systems level, it was recommended that concerted efforts focus on fostering a culture of public service. Key to this effort is the ongoing identification of CAMHD's role as service facilitator beyond that of a gatekeeper. Although gatekeeping is an important function, the general sentiment upon discussion of the annual evaluation is that there are potentially more areas of underservice than there are areas of excessive service. Following the initial focus on service expansion associated with the Felix implementation, CAMHD has established many checks and balances to monitor against potential excesses in recent years. To maintain the delicate balance between availability and gatekeeping, it was recommended that opinion leaders keep a focus on outreach and facilitating access to public services.

Improve community outreach

Several strategies were discussed to engage community partners to improve identification and referral of potentially underserved populations. One strategy was to target key populations and engage their access points. For example, truants were identified as a population that may be likely to qualify for SEBD services. Better identification and engagement of truants might be achieved by working with school-based peer review teams to perform a periodic review of all youth not returning to school. More generally, it was recommended that continued effort be invested in strengthening quality assurance teams at the district, complex, and school levels. Examples of strategies discussed included continued training in quality improvement at the supervisory level and consider formation of a state level team that could rotate among locals teams to provide mentoring in the quality assurance process.

As previously noted, it was also recommended that other key referral sources be targeted for outreach and engagement, such as primary care physician and child welfare offices. Strategies discussed above related to

marketing, regular training, and co-location of personnel are relevant here. Another specific recommendation mentioned was to promote the Juvenile Mental Health Court model for monitoring youth, holding agencies accountable, and further organizing the legal response to disruptive behavior problems. Community outreach may also be promoted by active involvement of CAMHD professional staff (e.g., clinical directors and clinical psychologists) in professional and community organizations. Regular public speaking appearances and networking with other professionals would likely increase CAMHD's presence at the local level.

Transitions

In addition to improving front-end referrals into the system, discussion also focused on transitions as high risk areas for service disruption. Numerous transition points were identified in relation to CAMHD services, including shifts between agencies (e.g., early intervention & CAMHD, SBBH & CAMHD, CAMHD & AMHD) and within CAMHD (e.g., in-home & out-of-home services, provider-to-provider). The previously discussed strengthening of interagency quality assurance and peer review was considered a good mechanism for addressing DOE & CAMHD transitions. It was recommended that CAMHD consider whether it might be appropriate to foster a direct transition from early intervention to CAMHD for some youth rather than relying on the dual transition pathway from early intervention to SBBH and SBBH to CAMHD.

Much of the discussion and recommendations focused on promoting higher levels of collaboration and smoother transitions within the CAMHD provider network. It was noted that the original plan under the Felix Consent Decree was to represent agencies through Community Children's Councils (CCC's), but the sentiment was that the CCC's have not always been as effective as originally hoped. One recommended avenue for addressing this was to conduct focus groups or another evaluation of what's working and what is not working with the CCC's, with the goal of increasing their functioning. In general it was felt that providers could get together and provide each other with better feedback, but that the CCC's may not be the best place to give inter-provider feedback due to their public format and the presence of family consumers.

Alternatively, it was recommended that CAMHD identify existing provider networks and work with them. One recommendation for strengthening the activity of these networks was to structure their discussion by requesting that they address key questions relevant to CAMHD services (e.g., how to improve transitions from out-of-home placement to in-home services, how providers can help expand identification of SEBD, etc.) CAMHD should consider disseminating these questions at the quarterly CAMHD provider meeting and ask members to request discussion of these questions at their other meetings. Another recommendation was that a regular provider workgroup or workshop be assembled to address such question and also create opportunities for providers to interact with various dignitaries.

Yet another recommendation for promoting smooth transitions with the CAMHD array was to consider contracting for multiple levels of care within provider agencies. The rationale for this suggestion was that transactions within a provider agency may be more efficient and effective than transitions between agencies. Finally, it was noted that the reliance on care coordinators to manage Coordinated Service Plans (CSP's) may coincide with less provider investment in the coordination process and a feeling of disempowerment compared to when providers have direct responsibility for managing coordination. It was recommended that CAMHD re-evaluate the CSP procedures and the locus of responsibility for their implementation. CAMHD has developed several resources for promoting smooth transitions among providers (e.g., practice standards, CAMHMIS clinical reports, monitoring for inclusion of transition plans in CSP's, etc.) and it is recommended that CAMHD promote ongoing use of these resources at the local level to promote smooth transitions within the CAMHD system.

Utilization of Out-of-Home Services

Out-of-home services were identified as the area of greatest potential overutilization. Specifically, Community-Based Residential (CBR) services were used excessively relative to Therapeutic Group Homes (TGH) and Therapeutic Foster Homes (TFH). The annual evaluation identified several factors that predicted out of home placement. These included older age, interagency involvement, disruptive behavior and substance-related diagnoses. Focus on these issues contributed to a number of recommendations.

Provide concrete guidance for level of care decision-making

It was recommended that materials be developed and disseminated from the CAMHD central office that clearly delineate the recommended conditions for using CBR, TGH, and TFH. The specific suggestion was to develop and train on a decision tree outlining selection of CBR vs. TGH vs. TFH. It was speculated that treatment teams think that TFH is better than TGH because it is individualized whereas CBR is better than TGH because on-site education in included. It was also recommended that CAMHD clarify options for adding additional staffing for difficult youth and for the supplementing educational component of treatment within TGH when needed.

Emphasize Parent Responsibility and Treatment

Strengthening parents and families remains central to minimizing out-of-home placements. Consistent with the CASSP principles, CAMHD should continue to maintain an organizational culture focused on parent responsibility and treatment. Anecdotal reports indicate that it is not uncommon to encounter a mentality of "saving" kids from problematic parents, teachers, and environments. Discussion emphasized that such a "protective" mentality may support "jumping" to place kids, rather than clearly working to strengthen families and communities. Specific recommendations were not detailed in this regard, but local opinion leaders who model a strengths-based "can do" attitude and collaborative environment are one likely mechanism. Continued support, development, and integration of a strong parent partner organization is also recommended. Finally, increased use of respite services to support families was discussed. Although it is clear that use of respite has reduced, it is unclear whether respite services reduced out-of-home placements when used. Therefore, it was recommended that further analysis of respite care be conducted to determine whether it occurred prior to out of home placement and help prevent out-of-home placement. A quality study examining the reintroduction of respite into the practice standards and guidelines should be considered.

Focus on Prevention

Discussion addressed both front-end prevention of out-of-home placement and back-end reunion with home-based services. Many of the back-end recommendations focused on the transition issues discussed above. Therefore, the primary additional recommendation was that efforts be made to identify youth before they need more acute care and to provide aggressive therapy for these youth at a high level when an out-of-home placement risk is identified.

As previously noted, justice involvement and disruptive behavior disorders were among the factors associated with out-of-home placement. This findings support the recommendation that concerted efforts be focused on the education of justice workers statewide in terms of community treatment options. It was noted that presently, care coordinators carry the brunt of this effort through their daily activities and involvement in court hearings. Several people noted that when counsels from the Attorney General's (AG) office were invested in and well informed about mental health problems and services, a positive difference in outcomes was noted. On Oahu, monthly meetings are held between CAMHD staff and the AG office. It was recommended that CAMHD consider establishing similar meetings in other regions where they do not exist.

Target Conduct Problems

Discussion noted that considerable progress has been made in treating youth with conduct problems outside of the hospital setting. However, the general sentiment remains that many youth with conduct problems should not need to be treated in highly restrictive settings (e.g., CBR). The increased use of Multisystemic Therapy (MST) as an evidence-based community alternative to institutionalization and the positive outcomes associated with MST services support the recommendation that the appropriateness of MST be considered for youth with conduct problems. The CAMHD Factbook for FY 2003 indicates that 35% of youth with a disruptive behavior diagnosis received one or more days of MST while 54% received one or more days of an out-of-home services (26% received one or more days of CBR). Of youth in CBR, 20% received one or more days of MST, 33% had a primary diagnosis of disruptive behavior, and 25% had a comorbid diagnosis of disruptive behavior. Close monitoring and promotion

of referrals to MST for youth with disruptive behavior was recommended. Further, examination of the blue menu of evidence-based services indicates that many treatments other than MST have moderate support for their efficacy with disruptive behavior or delinquency problems. Focused monitoring and promotion of these other services is also recommended.

Child Status

Earlier Identification and Treatment

In addition to the focus on prevention of out-of-home services, early identification and treatment were recommended as system-wide improvements. The annual evaluation found that the average CAFAS scores at registration to CAMHD were approximately 110. Since a CAFAS score of 80 represents the guideline for functional impairment defining SEBD eligibility, this implies that youth are not being identified until their functioning has deteriorated well past the point of eligibility. This may imply that the referral process is crisis focused, that a gatekeeping mentality might prevent initiation of services for moderately severe problems, or that systematic surveillance systems are not in place.

It was recommended that CAMHD promote early identification by reviewing and clearly identifying screening mechanisms. One avenue for this is the Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program that requires both physical and mental health screening. In the most recent data available on the CMS website (FY 2000: http://www.cms.hhs.gov/medicaid/epsdt/ep2000.pdf), Hawaii reported that 73,424 youth between 3 and 18 years of age were eligible for EPSDT services, 39,201 youth between 3 and 18 years of age were eligible for one or more initial or periodic screenings during the year and that 23,687 (60%) received at least one screening. If 3% to 5% of youth were expected to meet SEBD eligibility criteria, then approximately 2,203 to 3,671 youth eligible for EPSDT should meet SEBD criteria, roughly 1,176 to 1,960 youth eligible for screening during the year should meet SEBD criteria, and around 711 to 1,184 youth should be identified. CAMHD could consider promulgating recommended indicators for identifying mental health needs during screening and procedures for follow-up assessments to identify youth when their functioning enters the SEBD eligibility range. Also, as noted above, continued development of the DOH-DOE peer review process was recommended.

Understand Child Improvements

In addition to promoting early identification and treatment, it was discussed that best practices and placement guidelines could be enhanced through better understanding of child improvements. The outcome analyses in the annual evaluation were viewed as a good step, but further examination was recommended. For example, analysis of youth identified as group home successes (e.g., “best customers”) could help identify factors contributing to change and facilitate identification of other youth in the system who may be appropriate for group home services. More broadly, it was recommended that CAMHD continue to develop its system for evaluating and understanding what works best for CAMHD youth.

Quality Improvement Processes

The last major set of recommendations related to continued development of CAMHD’s quality improvement processes. The general sentiment was that quality improvement processes at CAMHD have continued to develop in a very positive direction. Therefore, recommendations focused on strengthening the current system.

Change Structure of Performance Improvement Steering Committee (PISC)

Over the past years, the availability and delivery of data has increased dramatically. This information is much more organized and PISC members are developing a better understanding of the available data. Therefore, it was recommended that PISC should refocus its structure to promote more time for discussion of the implications and use of data and less time on data presentation.

Develop Local Quality Processes

The preceding comments regarding PISC are also relevant to local quality improvement processes. It was recommended that CAMHD should continue to support use of quarterly performance data at the Family Guidance Centers and continue to encourage sharing of performance solutions across centers. These supports could take various forms may look similar to those previously described with respect to district QA, complex QA, and peer review. Review of quality information at network meeting and discussion of corrective action plans and working solutions were viewed as positive steps in this direction and were encouraged to continue. Skilled personnel could also be identified who could attend local quality meetings to promote more site specific mentoring in data use and interpretation. Ongoing dissemination of statewide performance information to local settings may also help model effective data use and interpretation and promote broad feedback for generating statewide solutions.

Evidence-Based Services

Finally, CAMHD professionals should provide strong leadership in the use and diffusion of evidence-based services. CAMHD should consider conducting a survey of attitudes and intention to use evidence-based services to get a reliable sense the current climate. CAMHD seems to have progressed through the “early adopter” phase and now needs to maintain enthusiasm, interest, and daily integration of evidence-based services. CAMHD should continue to develop and disseminate tools for evidence-based decision-making and monitoring of evidence-based services that build on the Evidence-Based Services Committee products and the CAMHMIS clinical report module.